Consent Form: Orthognatic Surgery

Orthognatic surgery is performed in order to fix congenital, developmental and acquired deformities of the jaws. The surgery is designed to restore the proper dental relationship and correct positioning of the jaws. The surgery is performed under general anesthesia.

Name of patient: _____

Last Name First Name Father's Name I.D.

I declare and confirm that I received detailed verbal explanation from:

Dr. _____

Last name First Name

regarding the need to perform orthognatic surgery _____ (type of surgery)

(Hereinafter: the "Principal Surgery").

I was informed of the expected results, the possible alternative treatments under the circumstances of the case and of the limited ability to correct the defect by surgery.

It was also explained to me that as a result of the surgery, a significant change might occur in my facial appearance, which is unpredictable. It was explained to me that after the surgery, an additional surgery and/or rehabilitative orthodontic treatment might be required. The alternative treatments were considered by me prior to choosing this treatment.

I was also informed that smoking, untreated gum disease and diabetes significantly enhance the risk of complications and risks.

I was informed of the importance of quitting smoking before and after the treatment, of treating my gum disease and controlling my diabetes.

I was further explained that undergoing surgical treatment while using medications for the treatment of bone diseases such as osteoporosis, metastases, multiple myeloma, especially combined with steroid therapy, smoking and diabetes enhances the risk of chronic inflammation up to necrosis of the jaw bones.

I was informed of the side effects of the Principal Surgery, including swelling, pain and subcutaneous hematoma in the face and neck, temporary injury to the gums and temporary or permanent limitation in mouth opening. I was also informed of the possible complications of the Principal Surgery, including permanent injury to the gums, pains in the jaw joint, mild occlusal disorders, facial nerve injury, which means temporary or permanent loss of sensation.

In addition, I was informed and I understand that during the course of the Principal Surgery, it might be necessary to extend or change the scope of the surgery or to use other or additional procedures, including additional surgical procedures, which are currently completely or partially unpredictable, but their meaning has been explained to me. I therefore agree to same extension or change in the surgery or to the performance of other or additional procedures, including surgical procedures, which, according to the institution's physician / the treating physician will be vital or necessary during the Principal Surgery.

It was explained to me that the Principal Surgery is performed under general anesthesia and that the explanation on the anesthesia will be provided to me by an anesthesiologist.

I am aware and agree that the Principal Surgery and all other procedures will be performed by anyone to whom it will be assigned in accordance with the procedures and guidelines of the medical institution and that I was not assured that all or part of them would be done by a specific person, provided that they are performed with the level of responsibility as acceptable at the medical institution and in accordance with the law.

I understand the importance of providing accurate health information and following any instructions I receive from the staff / physician, including the maintenance of oral hygiene, and attending for checkups as frequently as required.

I hereby give my consent to the Principal Surgery.

_____

Date Patient's Signature

_____

Name of Guardian (Relationship) Guardian's Signature

(When patient is legally or mentally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

_____ _____ _____

Name of Physician Signature License No.